

LETTERS

SIMPLIFYING CONSENT INCREASES HIV TESTING AND NEW CASE DETECTION: THE SAN FRANCISCO EXPERIENCE

We read with interest the impact of New York State's streamlined HIV testing consent procedures on HIV testing rates, and we were pleased to see that the results were consistent with our experience in San Francisco.¹ However, we would like to correct an inaccuracy. Wing argued that the lack of a control group in our analysis decreased the strength of our conclusions. We had published a one-year follow up of our initial report in which we included both internal and external control groups, explored how the policy change affected different subpopulations, and explored whether the increase in HIV testing rates was sustained beyond the first few months after the change in policy went into effect.²

In those analyses, we found no changes in monthly HIV testing rates in a comparison medical center in San Francisco during the same period, suggesting that the increased rates reported at our institution were not likely to be related to changes in HIV testing practices in the community or increased awareness of HIV screening recommendations at the patient level. Similarly, we found no increases in monthly testing rates for tests other than HIV at the



A boy rests on the mud in a dried-up section of the Euphrates River near Jubaish, Iraq. Photograph by Moises Saman. Printed with permission of *The New York Times*.

institution where the new HIV testing consent policy was implemented. Therefore, it seems unlikely that changes in general testing practices within the study institution could have accounted for the increases in HIV testing. The increases in the monthly HIV testing rates were sustained during the study period and were more pronounced among minorities and populations at highest risk for HIV infection. Most importantly, our analyses showed that increased testing, particularly among underserved populations at high risk for HIV infection, led to a significant increase in positive HIV tests after the policy change.

We feel that the number of HIV infections identified is the most important outcome of any intervention targeting HIV testing, and we encourage researchers to look into this outcome in future studies. ■

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doi:10.2105/AJPH.2009.173591

Contributions

All authors contributed equally to the conceptualization and drafting of this letter.

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1. Wing C. Effects of written informed consent requirements on HIV testing rates: evidence from a natural experiment. *Am J Public Health*. 2009;99(6):1087–1092.
2. Zetola NM, Grijalva CG, Gertler S, et al. Simplifying consent for HIV testing is associated with an increase in HIV testing and case detection in highest risk groups, San Francisco January 2003–June 2007. *PLoS One*. 2008;3(7):e2591.

WING RESPONDS

The letter by Zetola et al. revolves around 3 studies concerned with the way that HIV

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testing consent procedures affect HIV testing rates. All 3 studies conclude that written informed consent requirements lead to lower HIV testing rates.

The 3 studies analyzed different populations. In my article, I compared estimates of population HIV testing rates in New York and a set of other states before and after New York streamlined its HIV testing consent procedures.¹ The data were collected from representative samples of state populations, and my main finding was that streamlined consent increased testing rates by about 31%.

Zetola et al.² compared HIV testing rates per 1000 patient visits in a set of institutions in California operated by the San Francisco Department of Public Health Medical Care System (PHMCS) before and after the PHMCS repealed its written informed consent requirements for HIV tests. Zetola et al. found that there was a 33% increase in HIV testing rates after the consent procedures were repealed.

In another study, Zetola et al. studied the same PHMCS policy change one year later.³ The follow-up study included a large, university-based medical center in San Francisco as a comparison group. Data limitations prevented Zetola et al. from computing testing rates per 1000 patient visits in the comparison medical center. As a substitute, they studied testing rates per 10 000 samples tested for any condition at the comparison medical center. The results were similar to those reported in the 2007 study. Both the original and follow-up study of the PHMCS policy change were concerned with testing rates defined for the population of people who visited a particular set of medical institutions.

As Zetola et al. point out in their letter, the follow-up study found that changes in HIV testing rates either did not occur or were very small in the comparison medical center. The control group was not ideal because using that group required comparing testing rates per patient visit to testing rates per test ordered, but it did strengthen the conclusions of the San Francisco study. The real contribution of the follow-up was the analysis of how consent procedures affected testing in different subpopulations and how consent affected the number of positive test results.

Like all observational studies, the studies discussed here have weaknesses. Nevertheless,

it is encouraging that the studies found similar effects in different settings using different research designs. The mechanisms by which consent procedures affect testing decisions and the extent to which testing policy affects the identification of HIV infections represent important areas for future research. ■

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This letter was accepted June 25, 2009.

doi:10.2105/AJPH.2009.173831

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PRIOR REPORTS OF MEDICAL PROBLEMS AMONG INMATES

In the article "The Health and Health Care of US Prisoners: Results of a Nationwide Survey," Wilper et al. state, "We are not aware of any study analyzing the prevalence of common chronic conditions or of access to medical and psychiatric care among the incarcerated population as a whole."¹(p666)

We believe that readers should be aware of L.M. Maruschak's 2006 study, "Medical Problems of Jail Inmates,"² and her 2008 report, "Medical Problems of Prisoners."³ Also, D.J. James and L.E. Glaze coauthored a study, "Mental Health Problems of Prison and Jail Inmates," in 2006.⁴ These 3 publications presented analyses of data from 2 Bureau of Justice Statistics surveys, "Survey

of Inmates in State and Federal Correctional Facilities, 2004" and "Survey of Inmates in Local Jails, 2002" (available at <http://www.icpr.umich.edu/NACJD/ncrpc>), which were the 2 data sources used by Wilper et al.

Also, it would be helpful for the authors to clarify whether they believe that the figure they cite of twelve million annual releasees from jails and prisons represents unique persons or reflects some persons passing through institutions more than once in a one-year period. ■

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This letter was accepted June 16, 2009.

doi:10.2105/AJPH.2009.174953

Contributions

A. Spaulding oversaw the writing of the letter. V. McCallum helped research the letter.

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WILPER ET AL. RESPOND

Thanks to Spaulding and McCallum for highlighting these analyses, which provide a useful complement to the data we presented. The initial draft of our article included a reference to the 2006 Maruschak paper¹ as well as the monograph by James and Glaze.² These